Agenda Item 3
5/16/07 Meeting

Managed Risk Medical Insurance Board
April 18, 2007, Public Session

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Sophia Chang, M.D., M.P.H., Richard Figueroa, M.B.A
Ex Officio Members Present:	Warren Barnes (on behalf of the Secretary for Business, Transportation and Housing), Bob Sands (on behalf of the Secretary for California Health and Human Services Agency), and Jack Campana
Staff Present:	Lesley Cummings, Ruth Jacobs, Janette Lopez, Terresa Krum, Ronald Spingarn, Seth Brunner, Mary Anne Terranova, Ernesto Sanchez, Renee Mota-Jackson, Carolyn Tagupa, Ruben Mejia, Adrienne Thacker, Melissa Ng

Chairman Allenby called the meeting to order.

REVIEW AND APPROVAL OF MINUTES OF March 7, 2007 MEETING

The Board reviewed the minutes from the previous meeting.

A motion was made and unanimously passed to approve the minutes of the March 7, 2007, meeting as presented.

HEALTH CARE REFORM UPDATE

Lesley Cummings informed the Board that AB 8, authored by Assembly Speaker Nunez, and SB 48, authored by Senate Pro Tem Perata, will be heard during the week of April 23, 2007. The Governor's Office is holding a series of stakeholder to explain the core approaches to the Governor's Health Care Reform plan.

STATE LEGISLATION UPDATE

Legislative Summary

Mary Anne Terranova provided the Board with an update on state legislation and asked if there were any questions. Dr. Crowell inquired as to what happened with the hearing relevant to AB 2 (Dymally) concerning additional funding for the

Major Risk Medical Insurance Program (MRMIP). Ms. Terranova said that the bill was passed by the Assembly Health Committee.

Ronald Spingarn, Deputy Director of Legislation and External Affairs, provided updates on AB 1 (Dymally and Laird) and SB 32 (Steinberg). These bills concern expansions of coverage for children. MRMIB staff will be closely watching both bills and will report more information about them to the Board at the next meeting. Mr. Spingarn introduced Cynthia Reed, recently hired as a Legislative Analyst at MRMIB.

Chairman Allenby asked if there were any questions or comments. There were none.

STATE BUDGET UPDATE

Terresa Krum, Deputy Director for Administration, provided an update on the state budget related to MRMIB. She reported on recent budget subcommittee actions in the Assembly and Senate, particularly noting the approval of positions to implement changes required by SB 437 (Escutia).

Chairman Allenby asked if there were any questions or comments. There were none.

FEDERAL BUDGET AND LEGISLATION

SCHIP Reauthorization

Mr. Spingarn noted that there has been a great deal of activity in Washington, D.C. regarding SCHIP reauthorization, and that MRMIB staff has been meeting and talking with people to make sure that we are informed about these activities. He stated that Lesley Cummings, Janette Lopez and he have visited D.C. to learn about SCHIP reauthorization activities and to talk about California's Healthy Families Program.

Mr. Spingarn summarized highlights from HR 1335, a federal bill to reauthorize SCHIP, authored by Senators Clinton and Dingell. He also stated that Senators Rockefeller and Snowe have a proposal also addressing SCHIP reauthorization that is expected to be introduced soon. He stated that staff will report back to the Board next month with more details.

High Risk Pool Funding

Mr. Spingarn updated the Board about federal funding to states' high risk pools, explaining the 2002 Trade Adjustment and Assistance Act had, for the first time, allocated federal funds for qualifying state high risk pools. California was not one of these states because of the $75,000 cap that California has for annual benefits

provided to our high risk pooling enrollees. The 2006 State High Risk Pool Funding Extension Act extended funds to qualified states to 2010. California still did not qualify for these funds, $75 million. However, no funds for additional grants have been included in the federal budget. A letter was circulated to states requesting them to sign on to a letter asking Congress to include another round of grants for states. Lesley Cummings signed on to this letter.

Chairman Allenby asked if there were any questions or comments. There were none.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Reports

Ernesto Sanchez said that HFP recently enrolled its 800,000th child into the program, marking a milestone.

Administrative Vendor Performance Report

Mr. Sanchez said that the contractor had an 81% level for a performance standard, falling slightly short of its goal pertaining to the number of seconds that a caller waits to speak with a live person on the HFP member line. Staff believes that this was likely due to the new HFP open enrollment process. Additionally, there were a large number of potential nonpayment disenrollments. Staff does not believe that this indicates a continuing trend.

Mr. Sanchez also noted that in February, the vendor had a 97.7% accuracy rate for eligibility determinations which technically meets the 98% standard.

Chairman Allenby asked if there were any questions or comments. There were none.

Payroll Deduction Update

Janette Lopez, Deputy Director of Eligibility, informed the Board that in the past some individuals and employers have requested MRMIB to consider payroll deduction for premium payment. They believe that doing so would improve the retention of children in the program. Staff has begun assessing the pro's and cons of providing for payroll deductions. Only one state, Wisconsin, allows for payroll deductions in its SCHIP program, and only one employer participates in it. While such a program would ensure that a parent would not forget to make a premium payment while employed with an employer offering the payroll deduction, coverage could be interrupted, and retention worsened, to the extent that employees change employers and forget to make their HFP payment directly. Further, authorizing such a program could exacerbate crowd out of employer coverage.

Chairman Allenby stated that the crowd out issue is a tough one and that the HFP authorizing statute requires the Board to be concerned about it.

Lesley Cummings, Executive Director, noted that there was some value in thinking through payroll deduction issues given that some of the larger health care reforms under consideration would require the Board to undertake such a program.

Chairman Allenby asked if there were any questions or comments. There were none.

Administration of General Anesthesia as a Covered Dental Benefit

Vallita Lewis presented an issue paper assessing whether it would be appropriate to broaden the circumstances under which dental procedures could be performed in the dental office after administration of general anesthesia. The HFP Advisory Panel has recommended that the Board do so. The paper Ms. Lewis presented describes existing HFP benefits, articulates the arguments of supporters for making the change, details the position of dental professional organizations and dental plans regarding the issue, describes how other states' SCHIP and Medicaid programs provide the benefit, analyzes issues associated with the possible change and makes a recommendation to the Board.

Staff does not recommend expanding the administration of conscious sedation and general anesthesia in a dental office, citing safety, access and cost concerns. However, if the Board wishes to make the change, staff suggests that 1) dental plans provide prior authorization for the benefit and 2) the Board adopt specific criteria for its application.

Current HFP dental coverage benefits include administration of local anesthesia, oral sedatives and nitrous oxide dispensed in a dental office. Conscious sedation and general anesthesia are specifically excluded as covered dental benefits unless administered during covered oral surgery. They can be provided (under the health benefit) when the procedures are done in a hospital and where a child's circumstances meet certain criteria, namely the child is under the age of seven, is developmentally disabled or in compromised health and requires a medically necessary procedure.

Currently, dental plans refer HFP children needing general anesthesia for dental procedures to the child's health plan. Referrals are made when the children have such medical conditions as autism, bipolar disorder and Downes Syndrome, which make it difficult for the child to communicate, respond to commands or otherwise be treated in a dental office.

Chairman Allenby noted this issue had been heavily debated before the Board several times in the history of HFP, including when HFP benefits were first established.

Ms. Lewis reminded the Board that Dr. Paul Morris, representing pediatric dentists on the HFP Advisory Panel, presented a whitepaper to the Advisory Panel recommending that MRMIB revise its dental benefits to allow general anesthesia and conscious sedation to be performed in a dental office under the same circumstances currently allowed for administration in the hospital setting. Supporters of this change maintain that some Healthy Families children do not get necessary dental care because of difficulties coordinating care with health plans when general anesthesia is required. They contend that changing the covered benefits will improve timely access for members who need general anesthesia for dental procedures as the dental plans will no longer need to coordinate with health plans to schedule a room in a hospital or surgical center to have general anesthesia administered. They believe that costs of providing the service in a dental office will be less than in the hospital setting.

At its May, 2006 meeting, the Advisory Panel approved a motion recommending to the Board the change proposed by Dr. Morris. Jack Campana, the HFP Advisory Chair, presented the recommendation at the October 2006 Board meeting at which time the Board directed staff to prepare the report being presented today.

Staff have since clarified with Dr. Morris that he is actually proposing that children with behavior issues receive general anesthesia in the dental office. Staff's view is that this represents a broadening of the existing criteria as children are now referred primarily due to their medical condition rather than due to behavioral issues. Several plans also believe that inclusion of children with behavioral issues would significantly expand the circumstances when general anesthesia would be administered in the dental office.

Ms. Lewis reported that she had surveyed other SCHIP programs on how they handle this benefit it. She received responses from eight states. Of these, four do not cover office-based general anesthesia as a covered benefit. Four other states provide it as a covered benefit in a dental office under specific and restricted circumstances. In most of them, dental phobia or anxiety is included in the criteria only in conjunction with a severe or significant medical condition.

Ms. Lewis reviewed the factors impacting the feasibility and appropriateness of making the benefit change. This includes an assessment on impact on access to care, the availability of anesthesia providers for inclusion in dental plans networks, cost implications and safety issues. She indicated that proponents have not provided specific data to MRMIB demonstrating that there is an access problem. And, the majority of dental plans have not reported problems with the health plan denying referral for children in HFP. Further, some dental plans are

concerned about their ability to adequately recruit sufficient numbers into their providers' networks, especially in more rural areas of state. She also anticipates that the proposed change would increase dental plans' cost which would be passed on to the state through higher capitation rates paid to plans.

Ms. Lewis then reviewed the views expressed by the dental plans on the proposed change.

Ms. Lewis concluded by saying that staff does not recommend changing the benefit as proposed based on her analysis. She noted that if the Board did wish to change the benefit, it be done under the following parameters: Specific criteria should be established clearly describing the circumstances when conscious sedation and general anesthesia can be administered in the dental office; Authorization due to a child's behavior issues should occur only in conjunction with severe or complex dental problems or procedures; and, prior authorization by a dental plan should be required to ensure uniform and consistent application of the criteria.

Chairman Allenby asked if there were any questions or comments.

Dr. Crowell stated the she appreciated the work of the staff, and that it seemed that there was significant safety issues involved in the use of anesthesia on children in a dental office. There is an enormous amount of actuarial and administrative work that would be required to proceed with the recommendation.

Mr. Campana, HFP Advisory Panel chair, acknowledged the time, effort and consideration that have gone into addressing the general anesthesia issue. He acknowledges the possible risk issues, but thought they should be balanced against the risk of children forgoing needed treatment. He praised the quality of the review staff has presented, and asked it there is a way to establish safeguards that could address the problems.

Chairman Allenby asked if there were any questions or comments from the audience.

Dr. Paul Reggiardo, a pediatric dentist representing the California Society of Pediatric Dentistry informed the Board that he treats children with general anesthesia under the terms of the present benefit requirements. However, many of his colleagues do not have the access to an operating room in a children's hospital as he does and these dentists are not providing services to children. He indicated that the proposal is not an attempt to increase the number of children receiving care under general anesthesia or sedation but rather to change the venues under which they can receive it. He proposed that the Board make the benefit change but restrict it to the same criteria he uses to justify administration of anesthesia in the hospital.

He believes that the present requirement results in a lack of access for children. Hospitals have to have certain equipment to provide the benefit and it can be logistically difficult to arrange. The number of facilities with the equipment is very limited. Further, many pediatric dentists are simply not going to make arrangements to provide services in a hospital because of the distance and the logistical issues.

He noted that families with commercial coverage are in a better position to pay out of pocket to have the services delivered in a dental office, but that, given the incomes of the HFP population, this was not possible.

He disagreed that there was insufficient capacity to provide the services noting that the matter could be addressed by establishing criteria. He disagreed that costs would increase, arguing that the program would see cost savings because care in a dental office is cheaper than in a hospital. And he urged the Board to accept the recommendation of the HFP Advisory Panel.

Mr. Figueroa asked Dr. Reggiardo if he would continue providing services in a hospital if the regulations were changed. Dr. Reggiardo replied that he would.

Mr. Figueroa asked Dr. Reggiardo to confirm if he expected utilization of general anesthesia to increase if the benefit change were made Dr. Reggiardo replied that he did because the change would allow pediatric dentists with practice patterns of providing the services in the dental office to participate in HFP, which they are probably not doing now.

Dr. Chang asked if Dr. Reggiardo was recommending an amendment to the Advisory Panel's recommendation to specifically include medical criteria. Dr. Reggiardo agreed that criteria were necessary and suggested that the existing criteria be applied to the dental benefit. Ms. Cummings indicated that there was some disagreement about the meaning of one of the criteria, clinical status. Dr. Chang stated that there appeared to be a lack of clarity in exactly what the criteria would be and asked if Dr. Reggiardo's organization would work with the Board to establish it. Dr. Reggiardo indicated that it would.

Dr. Chang asked about Dr. Reggiardo's comments on access. Staff indicated that 136 dentists and anesthesiologists have a permit to administer general anesthesia and Dr. Reggiardo had stated that there were 500 pediatric dentists. Delivering the service takes both. Dr. Reggiardo indicated that oral surgeons also have their own ability to provide the service, but that they cannot provide it to a separate provider in another office. Dr. Chang commented that some of these providers may already be in networks serving HFP.

Dr. Chang asked Dr. Reggiardo about the experience of the providers with non-English speaking families, patients and families with lower literacy, raising the issue that they might not fully understand the risks involved in accepting services

in a dental office. Dr. Reggiardo replied that some of his colleagues work with migrant, non-English speaking populations, and colleagues around Orange County work with Asian populations through the MediCal and CCS programs.

Chairman Allenby stated it was clear to him that staff is concerned about safety, but that in some areas of the state there may not be adequate capacity. He asked Dr. Reggiardo if he would be willing to look at authorizing it only when there is no other alternative. Dr. Chang clarified that the Chair was referring to dental anesthesiologists.

Dr. Crowell noted that the Board uses the Rural Health Demonstration Projects (RHDP) to address access problems in rural areas and for special populations. She suggested the Board might want to do so for this problem.

Ms. Cummings reminded the Board of the staff recommendation that if the Board wanted to make the benefit change it do so consider several things, one of which was prior authorization.

Chairman Allenby stated that to do prior authorization, there must be established criteria. A dental plan may not be inclined to authorize the services if it had not taken such costs in consideration when submitting rates. So, there may be reticence.

Mr. Figueroa asked Ms. Lewis if the Benefits staff have received any complaints from families having problems getting the benefit. Ms. Lewis replied that staff had not and that, moreover, there are no data supporting the contention that large numbers of children that are not receiving access or timely access to care. Also, she pointed out that the Board had funded several projects through RHDP for pediatric surgical centers that administer general anesthesia to HFP patients needing dental procedures. Expanding these projects is another alternative the Board could consider.

Mr. Campana stated that many hours of testimony provided to the Advisory Panel showed that certainly a need was presented. Dr. Crowell stated this need was perceived by the provider. Mr. Campana agreed that it is as perceived by providers through a representative from the California Dental Association.

Dr. Crowell asked whether changing the benefit would require staff to renegotiate contracts with all of the health plan and dental plans.

Ms. Cummings stated that the Board would have to amend its regulations and then its plan contracts. She reminded the Board that it had received conflicting assessments of the impact of the change on rates and opined that rates would be an issue if the benefit were changed.

Dr. Crowell suggested that the Board track what is happening with utilization under MediCal given the new rates.

Chairman Allenby asked for any other comments.

Mr. Greg Alterton, with California Dental Association (CDA) informed the Board that the CDA endorses the comments by Dr. Reggiardo in support of providing general anesthesia as a benefit within the HFP and re-emphasized many of the arguments he had made.

Ms. Cummings indicated that staff would like to hear about the Board's view of use of general anesthesia solely for behavioral problems, as this appeared to be an issue where there are differing views. Ms. Lewis indicated that the benefit is now administered to discourage use for behavioral problems alone and that if doing so was authorized, it had the potential for significant increase in the use of the benefit.

Julie Day, Access Dental and Premier Access, stated the she previously worked for with Delta Dental and that she had worked with the pediatric surgery centers under the rural health demonstration project (RHDP). She thought the projects had made a significant contribution in providing services to children. She also reported a circumstance in her present job in which she had a very difficult time obtaining access to the benefit for a child with severe dental problems. Ultimately, the child went to a surgery centers 2.5 hours away. Ms. Day indicated support for more RHDP projects and support for the proposed benefit change. She thanked the Board for continuing to address the issue.

Negah Parsangi, the National Dental Director for SafeGuard Dental and Vision, informed the Board that she has never heard of any problems accessing the benefit under the present rules. She cautioned that she reviews requests for receipt of general anesthesia in the hospital setting and finds that the justification of the request is virtually always that a child is "uncooperative". Her view is that makes the proposed change, over time, administration of general anesthesia will become routine pediatric dental care. It can have serious medical implications and would likely be used when treating children who could get care other ways. She also expressed support for use of the benefit in pediatric surgery centers are a great idea. Mr. Figueroa asked Dr. Parsangi to describe how she handles requests based on a child's behavior. She replied that she calls the provider, obtains the medical history and treatment plan and assesses whether the provider has made serious efforts to provide the care.

Dr. Crowell asked how many requests she reviews .Dr. Parsangi replied she has been in her position for six months and has seen about one per week.

Mr. Barnes stated that the pervasive lack of data documenting a problem troubles him. He also thought that if the Board changed the benefit the most

reasonable economic assumption would be that demand, now restricted by the hospital setting, would increase dramatically, perhaps not initially but over time. It would be useful to determine what effect that might have financially over the long term. Chairman Allenby requested that staff consult with the Board's actuary to obtain an estimate.

Dr. Chang asked if Ms. Lewis was aware of when there would be data from Denti-Cal on the utilization impact of increased reimbursement rates. Ms. Lewis did not know but agreed to follow up.

Department of Health Services, Update on County Outreach Grants

Toby Douglas, Assistant Deputy Director, Department of Health Services (DHS), MediCal Program reported to the Board on the status of the outreach effort to enroll eligible but unenrolled children in Medi-Cal and HFP. DHS administers this program on behalf of both programs. The current year budget included funding to re-establish outreach grants and the budget for next year continues the funding. Building on local efforts of the children's health initiative coalitions, for the allocations, DHS focused on the top 20 counties where the uninsured eligibles made up about 93 percent of that population and provided allocations to those counties. DHS requested that the counties address four broad areas using innovative approaches for outreach, enrollment, retention and utilization and then worked with the counties to come up with county-specific plans. DHS started approving those plans in December 2006 and had approved all 20 counties by February. At the same time, MediCal identified a process for smaller counties, although DHS required that a county had to have a coalition in place for the last year to be eligible. DHS funded 12 smaller counties.

Mr. Douglas described the types of outreach efforts funded and planned indicating that they address retention and utilization, focusing on case management, continuing contact with the uninsured rather than those already enrolled in coverage. Counties will submit their first progress reports that will have another budget proposal to continue this funding.

Lesley Cummings said that Board packets contain information about each county's funding levels and a description of their outreach projects.

Department of Health Services Update on the Joint Medi-Cal and HFP Application

Toby Douglas continued updating the Board on projects of joint interest to the Board and DHS, addressing the status of the revised joint Medi-Cal and HFP application. DHS has begun working to make the Medicaid-HFP joint application form more consumer-friendly as a result of the commitment of the administration to these efforts through the 2005 budget. In the last two years DHS has convened meetings with stakeholders and, through the use of a consultant, has

reduced the required literacy level of the form from the 10th to the 7th grade level. DHS conducted focus groups on the form and made revisions based on the results. The new form eliminates fifty percent of the instructions for the application and has been translated it into 11 different languages. The final application will be available in spring 2007.

Department of Health Services Update on SB 437 Implementation

Toby Douglas next discussed DHS's activities in implementing SB 437 (Escutia). There are three major components to this effort. First, MediCal will conduct a pilot project on self-certification of income in Orange and Santa Clara counties. The pilot should be running by the beginning of summer. DHS has contracted with UCSF to evaluate the pilot over two years. If the pilot achieves the goals of expanding enrollment while maintain fiscal integrity of the program, DHS intends to expand it statewide.

The second piece establishes presumptive eligibility for HFP-eligible children who enter the system through county welfare offices. Counties will make the children presumptively eligible and then, using an electronic process, will forward the application to Maximus for final eligibility determination. DHS expects this project to start at the beginning of 2008.

Third, DHS is creating a Women, Infants and Children (WIC) gateway for entrance into Medi-Cal and HFP coverage. Many of the WIC subscribers are uninsured and eligible for Medi-Cal or HFP go to WIC offices. DHS is developing an electronic gateway that creates an application for coverage from the information collected by WIC staff. DHS is conducting a feasibility study on the appropriate gateway to capture all information.

Dr. Crowell said that the Department's efforts were wonderful.

Ms. Lopez reminded the Board that SB 437 also requires HFP to establish an income self-certification process at the time of a subscriber's annual eligibility review. She will be holding a meeting with advocates in May to get their ideas about the project.

Dr. Crowell said that the Department's efforts were wonderful. She expressed appreciation for the updates and requested that Mr. Douglas appear periodically to keep the Board up to date. Mr. Douglas agreed to do so and also indicated that DHS will make sure to have staff at the outreach meetings MRMIB staff hold with stakeholders every quarter.

Chairman Allenby thanked Mr. Douglas, asked if there were any questions from the Board or the public. There were none.

Recognition of Dennis Gilliam

Chaiman Allenby recognized Dennis Gilliam, MRMIB's Contract Administrator who is soon to retire from MRMIB. He noted that he had worked with Mr. Gilliam for many years, beginning at the then-Health and Welfare Agency and continuing on to the formation of MRMIB. Mr. Gilliam was one of the first staff hired by MRMIB. He pointed out that Mr. Gilliam serves as MRMIB's resident historian and conveyed hope that Mr. Gilliam will continue to serve in this capacity. He thanked Mr. Gilliam for his 17 years or more of service to MRMIB. Mr. Figueroa thanked Mr. Gilliam for his service noting that he had worked with him from the beginng of the MRMIB. He expressed appreciation for his can-do attitude always finding a way to make things work. Dr. Crowell praised Dennis for his faithful service pointing out his 100% success rate with getting regulations approved and contracts implemented.

Award of Contract for Phases II and III-Evaluations of HFP Mental Health Services
(Agenda item taken out of order.)

Ruben Mejia reviewed a document comparing the proposals submitted for evaluation of mental health and substance abuse services provided by HFP plans. Staff received four proposals. The review team concluded that one did not meet the minimum qualifications. The team then evaluated the remaining three proposals based on the criteria detailed in the solicitation document. Staff recommends hiring Macias because its proposal is comprehensive, cost effective and the work will be performed by people with direct experience.

Dr. Crowell commented that when she read the analysis and recommendations she was initially not compelled that Macias was the superior proposal. The APS proposal called for getting specific information about services delivered and health plan services, which were not specified under the Macias proposal – data she thinks to be very important for an effective evaluation. However, staff can include this element when negotiating the details of the contract and with this addition; she expressed support for the staff recommendation.

Chairman Allenby asked if there were any questions from the Board or the public. There were none.

Dr. Crowell made a motion authorizing the Executive Director to sign a contract with Macias Consulting. The motion was seconded and unanimously approved by the Board.

Further Analysis of the Health Plan Quality Measurement Report for Services Provided in 2005 (HEDIS)

Carolyn Tagupa, reviewed a revised version of the 2005 HEDIS report with the Board. She initially presented the report at the December 2006 Board meeting.

At that time, Board members had questions about demographic, ethnicity and language data in the report and directed staff to re-look at the data.

Staff undertook a more thorough examination of the linkages between HEDIS data and demographic data found in HFP enrollment data and found errors associated with those measure where plans report data using the hybrid method. The majority of plans choose to report HEDIS data using the hybrid method for the following measures: childhood visits, immunizations, well-child visits and adolescent well-care visits. This means that a majority of the plans report data on a sample rather than on all of the enrollees qualified to meet the criteria for that measure.

However, a handful of plans sent data records for all of their enrollees that met certain criteria, rather than just a sample. Staff obtained corrected data from the plans, re-ran the numbers, and results are in the revised report. She reviewed the changes to the report, which will be posted at www.mrmib.ca.gov.

Staff will exercise more care in the future, making sure that the numbers of members reported would be what we would expect, based on the sample size.

At the December meeting, Board members also questioned the data about access to a primary care physician for cohort number four – the 12 to 18 year olds. Members asked why the score was so high at 81 percent when the score for adolescent well-care visits remained low at 36 percent. The type of service may have accounted for some of the disparity in scores, but staff found another influencing factor not mentioned at the December meeting: HEDIS measures for this age cohort counts visits for a 2-year period, whereas the other measure looked at only a 1-year period.

Dr. Chang thanked Ms. Tagupa and staff for the revised analysis. She emphasized that the issues with the hybrid data enforce the need for MRMIB to use its purchasing power to encourage plans to improve its administrative data We continue to be serious about the work that the staff does with plans to share best practices and encourage a mandate and use of best practices.

Chairman Allenby asked if there were any questions from the Board or the public. There were none.

Appointment of HFP Advisory Panel Members
(Agenda item taken out of order.)

Ms. Lopez reminded the Board that at the March Board meeting staff presented guiding principles for filling vacancies on the Healthy Families Advisory Panel, and that there had been significant interest from persons seeking appointments to the panel. Based on the criteria adopted by the Board and after review of all applications, Staff makes the following recommendations for appointments:

Pediatrician - Dr. Leonard Kutnik; Business - Ron DeLuigi; Substance Abuse Provider - Elizabeth Stanley Salazar; Non-profit clinic representative - Karen Lauterbach, manager of the Community Health Insurance Program, Venice Family Clinic, and Los Angeles.

Upon a motion duly made, seconded and carried, the Board approved staff recommendations for the Advisory Panel

Ms. Lopez said staff are still recruiting to fill two subscriber vacancies on the panel and also will be recruiting for the county public health position as Lantha Thompson just resigned.

Chairman Allenby asked if there were any questions from the Board or the public. There were none.

Rural Health Demonstration Project (RHDP) Fact Book

Renee Mota-Jackson presented the 2007 Rural Health Demonstration Project (RHD) Fact Book. The Fact Book describes the history, funding, strategies, project solicitation criteria and project outcomes. Two hundred ninety-five projects have been funded since the beginning 9 years ago. Currently there are 66 projects; 36 of those will end in June. A substantial number of projects have continued operation after RHDP funding ended. She highlighted positive outcomes from several projects. She acknowledged Alba Quiroz-Garcia who had prepared the Fact Book.

Dr. Crowell thanked Ms. Mota-Jackson and commended her for a thorough, impressive report, highlighting the importance of the program. She noted that the Board had been groundbreakers on telemedicine—and was struck by its use for psychiatric services. She thought that it would be appropriate to include this feature in the evaluation of plan provided mental health services

Mr. Figueroa noted that the Governor is in Eureka now, doing a press conference at a telemedicine center at Open Door. They are consulting with a specialist from UCLA.

Chairman Allenby complimented staff on the report. He asked if there were any questions from the Board or the public. There were none.

Annual HFP Retention Report

Ms. Lopez reported on HFP retention. The retention rate continues to improve, increasing from 77 percent for 2004 to 78 percent for 2005.

Chairman Allenby asked if there were any questions or comments. There were none.

Community Provider Plan Update for San Diego County

Ms. Tagupa said that staff had completed the audit process for San Diego County. Community Health Group remains the community provider plan in San Diego with a score of 96 percent. The final report is available at www.mrmib.ca.gov and in the Board packet.

Chairman Allenby asked if there were any questions or comments. There were none.

MAJOR RISK MEDICAL INSURANCE (MRMIP) UPDATE

Enrollment Report

Ms. Cummings informed the Board that the take-up rate for MRMIP coverage has flattened out. Enrollment is still some 1500 slots below the enrollment cap and on a month-to-month basis enrollments are just keeping pace with disenrollments. She expressed the view that coverage cost was a major deterrent for take-up, noting that the size of the population rejected for coverage annually was in the neighborhood of 500,000 people. She asked PricewaterhouseCoopers (PwC) to assess MRMIP's rates relative to the rates of other high risk pools. PwC indicated that a quick review indicated that MRMIP rates were not out of step with those charged in other high risk pools. However, these pools too are experiencing flat enrollment unless they have premium subsidy programs for lower income people. Staff will talk more about this with the Board in May after PricewaterhouseCoopers presents its semi-annual estimate for the enrollment cap.

MRMIP Benefit Plan Design Update

Peter Harbage, Harbage Consulting, provided the Board with an update on his work reviewing the MRMIP benefit plan design. Harbage Consulting contracted with Bruce Abbe, a national high risk pool expert, to help facilitate meetings with key individuals and help with our analysis. To assist with the review of disease management, Harbage Consulting has also contracted with Dr. Robert Berenson from the Urban Institute, a national expert on disease management. The methodology for the review includes surveying selected states as well as interviewing MRMIP participating plans.

California has a unique model in that it uses multiple carriers to provide coverage. Most states use a single entity to provide coverage. California is also the only state that has first-dollar coverage. Every other state has some deductible, big or small.

Mr. Harbage reviewed some preliminary findings on disease management and high deductible coverage, indicating that he will provide his final report to the Board at the next meeting.

Mr. Figueroa, noting that Mr. Harbage had indicated that not all MRMIP plans provide disease management services to MRMIP subscribers, asked why this would be the case as it seemed counter-intuitive. Mr. Harbage stated that he needs to explore the issue with the plans further. Ms. Cummings said she believes it is because plans do not bear the risk of paying for or benefiting from the services. Mr. Figueroa stated there may be some element of that but also thought that the disease conditions (or lack there of) in the MRMIP population itself might be relevant.

Ms. Cummings stated that PricewaterhouseCoopers is looking at the impact on pool risk associated with high deductible coverage and expressed hope that this work will feed into Mr. Harbage's final report.

There being no further business to come before the Board, the meeting was duly adjourned at 1:10pm.